

## PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Sex  Male  Female Date of Birth: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Pharmacy Preference (include location): \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

Name of Medication	Dosage	How Often Taken

**ARE YOU ALLERGIC TO ANY MEDICATION?**  Yes  No. If yes, please list below:

Name of Medication	Type of Reaction

**SURGERIES and HOSPITALIZATIONS**

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes  No

If yes, please list type of problems: \_\_\_\_\_

List any surgeries you have had (including dates): \_\_\_\_\_

Have you ever been hospitalized for *non-surgical* reasons? Yes  No

If yes, please list hospitalizations: \_\_\_\_\_

**PLEASE LIST ALL DOCTORS INVOLVED IN YOUR CARE:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT or MOST RECENT OCCUPATION:** \_\_\_\_\_